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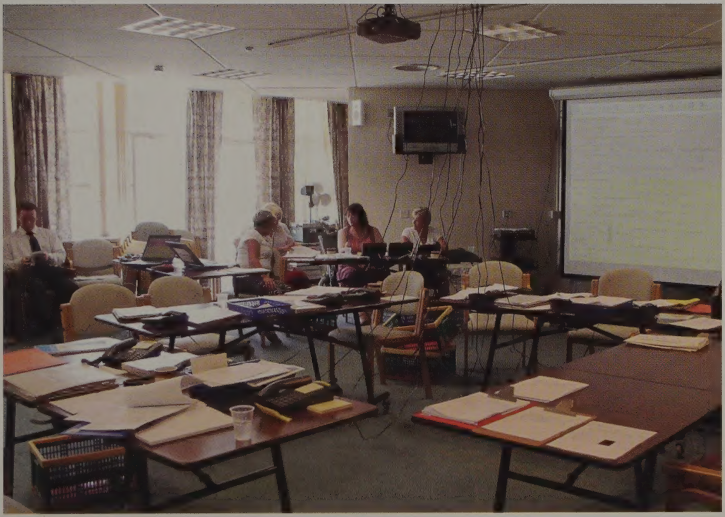
HEALTH AND SOCIAL SERVICES
A STATES OF GUERNSEY GOVERNMENT DEPARTMENT

109th ANNUAL MOH REPORT

14th ANNUAL DPH REPORT

Special theme:

Learning from others



Report for
Year 2007/08

HEALTH AND SOCIAL SERVICES DEPARTMENT

MEMBERS 2007-2008

Minister: **Deputy Peter Roffey**

Deputy Minister: **Deputy David Grut**

Members: **Deputy Hunter Adam**
Deputy Barry Brehaut
Deputy Mrs Diane Lewis

Non States Members: **Advocate Mark Dunster**
Mr Bruce Mansell

Front Cover – Testing the Major Incident Plan (MIP)

It has been at least twelve years since the MIP at the Princess Elizabeth Hospital was last fully tested. A 'mini *livex*' (live exercise) to test components of the Plan was therefore held in early June 2008.

Front Cover (top)

Simulated casualties arrive at the A&E at the PEH.

Front Cover (bottom)

The Emma Ferbrache Room set up as the MIP control room with the new 'electronic white board' in action.

All pictures courtesy of Mrs Steph Charlwood, Health Promotion Unit, PEH unless otherwise stated.

Health and Social Services Department
A States of Guernsey Government Department

Political responsibilities:

Promoting, protecting and improving the health of all, through the provision of hospital, community, social and public health services.

Core principles:

The following principles, developed from those agreed by the newly formed *Health and Social Services Department* in June 2004, have been taken from the HSSD Operational Plan 2007-2009.

'In the provision and delivery of health and social care, the HSSD believes it should:

- *work with other service providers to ensure that services are simple to use, effective and well co-ordinated;*
- *treat all people fairly, respect their privacy and dignity, be helpful and courteous, and pay particular attention to those with special needs;*
- *make services easily available to everyone who needs them, including using new technology, where appropriate, and offering choice wherever possible;*
- *be open and communicate clearly, honestly and effectively in plain language to assist people when using the services;*
- *put things right quickly and effectively, learn from complaints and have a clear and easy complaints procedure;*
- *consult and involve present and potential users, as well as staff, and use their views to improve services;*
- *develop knowledge and skills, but be guided by a common sense approach;*
- *use resources to provide best value for taxpayers and users.'*

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Acknowledgement

As always, I wish to thank all those who have contributed to public health initiatives, however broadly defined, over the past year, to the several other contributors to this Report, and especially to Mrs Steph Charlwood who took the photographs, Mrs Jenny Elliott who produced most of the various graphs and tables, and to my personal assistant, Mrs Yvonne Kaill, for once again producing and collating the Report.

■ 109th Annual MoH Report; Learning from others

GP to the Islands? (Map: Courtesy Digimap, Guernsey)

Welcome

Welcome to the 109th Annual MoH Report, and the fifteenth such Report with which I have largely produced.

It is also likely to be my last Annual Report, since my post has already been advertised and hopefully it will not take too long to recruit a suitable replacement.

I have therefore allowed myself the indulgence of taking a rather more personal and reflective view than in previous Reports, - in part a retrospective of what has been achieved in the fifteen or so years I have been on the island, and in part a look at the future health challenges likely to be facing my successor

Why do we need an MoH?

The rapid urbanisation and population growth which followed the Industrial Revolution led to widespread insanitary living conditions, industrial pollution and a large increase in communicable and food borne diseases.

Recognising that communicable disease was no respecter of social class, the Government of the day responded with the first Public Health Act of 1848. Amongst a number of reforms, this proposed the need for an independent *'Medical Officer of Health'* (MoH).

The 1848 Act was followed by the 'Great' Public Health Act of 1875, which made the office of Medical Officer of Health mandatory for all major towns and cities. Over one thousand such new posts were created in consequence.

Guernsey did not appoint an MoH until 1899, when a major outbreak of diphtheria led to 23 deaths, - 22 in the country parishes but only one in Town. A Special Committee of the Royal Court realised that the Parishes (who had traditionally dealt with matters of sanitation) did not have the necessary powers (or knowledge) to respond quickly and effectively to outbreaks of exotic imported disease.

Amongst their several recommendations was that an MoH should be appointed at a salary of £200 per annum *'with the powers necessary to combat the illness'*.

Guernsey's first MoH Dr John Brownlea arrived to take up his duties in October 1899, and I am only the ninth such person (and probably the third longest serving) to hold this Office over the past one hundred and ten years.

The 'independent' MoH Report

A potential 'conflict' of MoH's being based within local authorities was that Town and City Councils were traditionally dominated by successful local businessmen along with other powerful vested interests.

It was realised that if the MoH was to be able to act effectively to protect 'the public health', then he needed to be able to speak out against those who might be endangering this, however rich and powerful they might be.

The 1875 Act provided for *'security of tenure'* for the postholder (later amended so that he could *not* be dismissed without recourse to Parliament), and the duty to speak out in all cases where public health was seen to be endangered.

This position was paralleled in Guernsey, where at the first meeting of the newly appointed Board of Health in January 1900, it was agreed that *'All professional matters should be left to the MoH, except where he wishes advice'*.

The Annual Report was the vehicle by which the MoH could independently report *'on the state of the public health'*, identify influences likely to be *'deleterious to health'* and make all necessary recommendations to address these.

Annual MoH Reports have been published in Guernsey every year since 1899, (even during the latter years of the German occupation when there was a severe paper shortage), and I feel very proud to have been able to continue this unbroken tradition.

From MoH to DPH

Over the past one hundred years, there has been a huge change in the determinants of disease and the causes of death locally.

In particular, improvements in hygiene and sanitation, introduction of vaccination programmes, and the appropriate use of antibiotics means that almost all forms of communicable disease are now very much rarer, whilst deaths from these causes are very rare indeed.

In their place, diseases which relate to environmental factors, (e.g. asthma), lifestyles choices (e.g. smoking related diseases) or a combination of these (e.g. obesity and most forms of cancer) have become much more common.

In his last Annual Report (1989), the then Medical Officer of Health Dr Peter Lawrence called for the creation of a *Director of Public Health* for Guernsey. He concluded *'Public opinion and political decisions decide just how much of the total budget should be spent on healthcare…….it should be the Director of Public Health's responsibility to advise the Board how this budget might be used most effectively, from an understanding of epidemiology and the economics of the provision of healthcare.'*

Dr Lawrence decided to take early retirement in 1990, and public health advice was then provided by public health physicians seconded from the Dorset Health Commission until early 1994, when I took up my appointment as Guernsey's first *'Director of Public Health'*.

Firmly believing the much quoted aphorism of the philosopher George Santayana that *'Those who cannot learn from history are doomed to repeat it'*, I have studied the Annual Reports of my predecessors with interest, and often mused on the differences between how they saw their role, and the role I have tried to develop.

Some immediate differences would seem to be:

Medical Officer of Health	**Director of Public Health**
Reactive	Proactive
Reliant on Public Health Law	Persuasion and public relations are more important
Environmental factors prominent	Lifestyle factors prominent
Traditional public health 'domains'	'Whole system' healthcare
National comparisons	International comparators

Learning from others

One further difference is that despite being a British graduate, I had spent the eighteen years prior to taking up my appointment working in several States of Australia.

Healthcare in Australia is still nominally *'private'* with primary care practitioners charging a *'fee for service'* (but with a major reimbursement from the Federal Medicare or private insurance funds), and with secondary care services being the responsibility of the individual States.

Thus, healthcare in (say) New South Wales is somewhat different from that in Victoria, and different again from South Australia, Western Australia, etc. In effect, there are a series of *'natural experiments in healthcare'*, and ideas which appear to work in one State can readily be taken up by others.

I consider my eighteen years in Australia have been hugely useful to the time I have spent in Guernsey, compared with what I would have brought to the Islands had my career been largely within the NHS.

In particular, my experience taught me about working with a private primary care sector, and that healthcare strategy needs to be pragmatic, and not be afraid to borrow *'good ideas that work'* from others.

Many of our successful approaches in tobacco control were originally trialled in Australia and New Zealand, whilst other successful health promotion and disease prevention initiatives have been *'borrowed'* from the European Office of the World Health Organisation.

One consistent feature of this approach have been my attempts to try and place Guernsey's health in a wider international context, rather than just trying to compare ourselves with the NHS, which by international standards is not regarded as a particularly effective performer.

GP to the islands?

One of the issues highlighted by the transition from MoH to DPH is whether a Director of Public Health needs to be medically qualified?

The NHS and *Faculty of Public Health Medicine* (now renamed the *Faculty of Public Health*) have concluded that the post should be open to anyone with the necessary skills and experience, whether medically qualified or not, and many Primary Care Trusts in the UK have now appointed Directors of Public Health whose background lies in environmental health, health promotion or other non-medical public health disciplines.

During the fifteen or so years I have been in Guernsey, my role has evolved considerably from that outlined in my original job description, and now includes major responsibility for:

- Patient safety, clinical risk and *'clinical governance'* more generally
- Health records, clinical coding and healthcare information
- Caldicott (confidentiality) requirements.
- Health strategy
- Major incident preparedness

Although many of these functions could be performed by someone from a non medical background, there is no doubt that in the Guernsey context, an understanding of how hospitals (and doctors) function, through having *'been there yourself'*, is of undoubted benefit in trying to ensure that only high quality and appropriate care is given.

One consequence has been renewed debate amongst primary care doctors, the MSG and States Employed Consultants on whether Guernsey needs a *'Medical Director'*, and how this role would relate to that of the Director of Public Health? All the above parties see the advantage of having strong and well identified medical leadership, and negotiations are continuing about how such a post could be created (and funded).

But whether medically qualified or not, public health in Guernsey is definitely a job for the generalist, rather than a specialist. Looking back over the last fifteen years, I have been continually amazed by the sheer volume and variety of issues which regularly cross my desk, and I cannot help comparing this with the range and diversity of problems experienced by busy general practitioners in their surgeries. I hope the picture at the head of this section gives a light hearted 'take' on this aspect of the public health role in Guernsey?

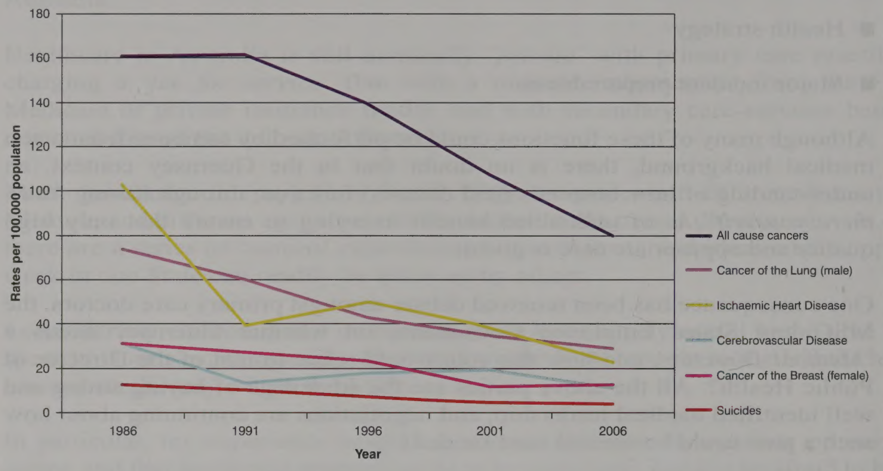
In conclusion, when the majority of medical practice is nominally *'private'*, whilst *'specialists'* are becoming ever more specialised, it remains important that the Health and Social Services Department, the States of Guernsey more generally, and the population themselves have a source of high level, credible, independent and objective medical advice.

This I have consistently tried to provide, and I am grateful to have had the opportunity to serve the people of Guernsey and Alderney in this capacity since 1994.

As I hope the next chapter will demonstrate, although we can point to substantial improvements in health over this period, we can also identify a number of major health challenges which my successor will need to address.

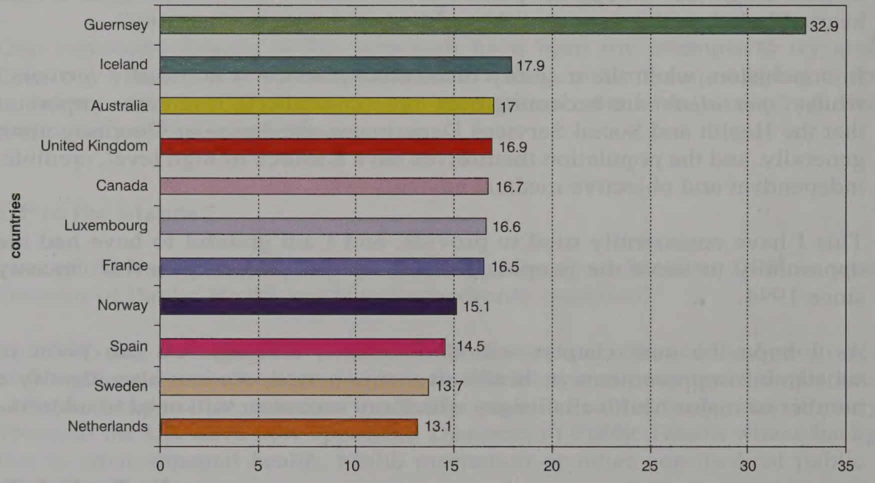
Dr David Jeffs
Director of Public Health

Figure 1 - Five year mean mortality rates for selected causes of deaths <75 years in Guernsey 1986-2007



Source: *Healthcare Information* Unit 2007

Figure 2 - Total public health spend as % total public revenue 2003



Source: Policy Council *'Guernsey Facts and Figures'* 2007
OECD *Health Data* 2006

What's approaching on the 'health radar'?

■ Improving life expectancy *(Figure 1)*

'Life expectancy at birth' is a traditional public health measure of the aggregated effects of the environment, social support and health services on overall longevity. During recent years it has been increasing by about one year in every five in most Westernised countries. When last calculated in Guernsey in 2004, *'life expectancy at birth'* was 80.4 years, - amongst the *'top ten'* in the World.

'Seventy five' years was previously regarded as a desirable and achievable *'life expectancy at birth'* for everyone, and epidemiologists and health economists accordingly introduced the concept of *'premature mortality'* or *'potential years of life lost'* (PYLL) for all deaths occurring before this age. During the five years 1989-1993, just three causes accounted for 80% of all *'potential years of life lost'* in Guernsey:

- *'all cause cancers'*	(1,293 years)
- circulatory diseases	(831 years)
- injuries and suicide	(410 years)

Figure 1 confirms that there have been continuing substantial falls in these major causes of premature death, although during recent years, this trend seems to have *'plateaued off'*?

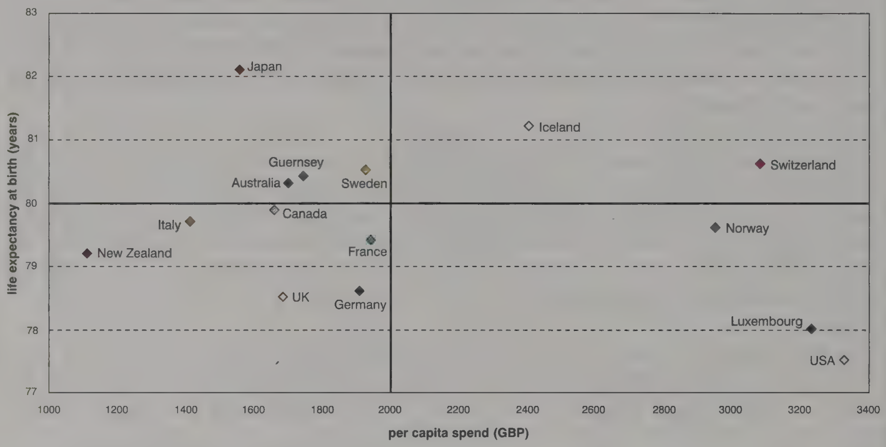
■ Paying for healthcare *(Figure 2)*

Better health does however come at a price, and *'total healthcare costs'*, i.e. Government expenditure plus personal contributions, are by far the largest component of overall expenditure in most national accounts. In 2005, these ranged from 7.5% of GDP in the UK to 14.7% in the US, with most Western European countries spending between 8.5% and 10.5% of GDP on *total* healthcare. As a percentage of our GDP, Guernsey's *total* healthspend was only 7.9% of GDP in 2005.

However, although Guernsey has a relatively high *'GDP per capita'*, it prides itself on still being a *'low tax'* jurisdiction, and total Government revenue (as a percentage of total GDP) is low at around 20%, compared with 35% to 55% of GDP in many European countries.

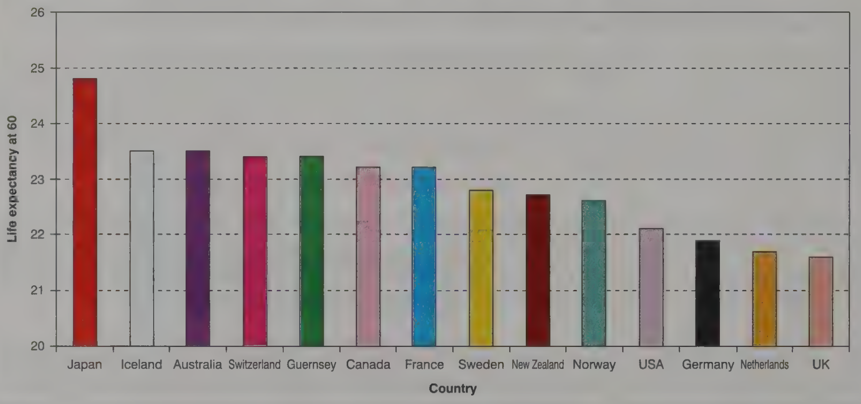
As shown in *figure 2*, our total Government healthspend as a percentage of total public revenue is therefore comparatively high at 32.9%, meaning there is only limited scope to absorb rising healthcare costs. However, health economists increasingly account *'improved population health'*, not just as a financial cost, but also as an economic benefit. Certainly for Guernsey, a healthy, productive and creative total population can only improve our overall competitiveness and sense of community wellbeing.

Figure 3 - Total per capita healthcare spend (GBP) and life expectancy at birth in various OECD countries and Guernsey 2004



Source: OHE *Compendium of Health Statistics* 2007

Figure 4 - Life expectancy at 60 -
Guernsey and other selected jurisdictions 2004



Source: Government Actuary 2008
OECD *Health Data* 2006

- **Value for money' *(Figure 3)***

As well as considering total healthcare expenditure as a percentage of GDP, it is also useful to have look at such spending in absolute terms. In 2007 (a year of *'restraint'*), Guernsey spent £1,966 per capita on total healthcare, which for the first time was less than the UK (£1,984 per capita). Both these figures were in the broad range for other European countries (£1,600 - £2,400 per capita per annum).

As pointed out above, *life expectancy at birth* is the end result of a number of other variables, and not just healthcare expenditure. However, it is interesting to compare *'per capita healthcare spend'* with life expectancy in various countries as shown in figure 3.

There are no clear linear relationships, but it would appear that:

- Some countries (such as Iceland and Switzerland) spend quite a lot on healthcare, and enjoy relatively high life expectancy.
- Others such as Luxembourg and the US also spend large amounts, but do not enjoy such high life expectancy.
- Some such as UK, Germany, New Zealand and France spend relatively less, but have a lower life expectancy at birth.
- A fortunate few (Japan, Guernsey, Australia, Sweden) have relatively low *total* healthcare costs, but are fortunate to enjoy a greater life expectancy.

- **Life Expectancy at 60 *(Figure 4)***

'Life expectancy at birth' may largely reflect the quality of the environment, social and health services, etc. but 'life expectancy at 60' far more reflects the *'personal health choices'* we choose to make throughout our lives, e.g. whether we smoke, how much alcohol we drink, whether we exercise regularly, etc. Here too Guernsey scores comparatively well *(figure 4)*.

In 2000, Mr Derek Wanless, former Chief Executive of the National Westminster Banking Group was asked by the then Chancellor, Gordon Brown to analyse and advise on likely future NHS healthcare costs.

In his Final Report *'Securing Good Health for the Whole Population'* (February 2004), he identified four *'drivers'* of increasing healthcare costs:

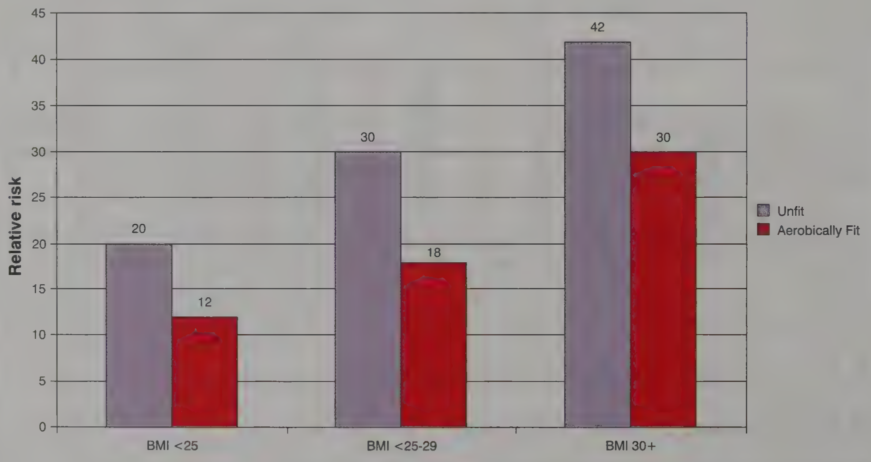
- Rising patient and public expectations.
- Desire to deliver a *'World class service'*.
- Changing health needs of the population.
- Technological development and medical advance.

Figure 5 - World Cancer Research Fund Recommendations for cancer prevention

1. Be as lean as possible without becoming underweight.
2. Be physically active for at least 30 minutes every day
3. Avoid sugary drinks and limit consumption of energy-dense foods
4. Eat a variety of vegetables, fruits, wholegrains, and pulses
5. Limit consumption of red meats and avoid processed meats.
6. Limit daily alcoholic drinks to two for men/one for women
7. Limit consumption of salty foods and foods processed with salt
8. Don’t use supplements to protect against cancer
9. Mothers to breastfeed exclusively for up to 6 months and then add other liquids and foods
10. After treatment, cancer survivors should follow the Recommendations for Cancer Prevention.

Source: World Cancer Research Fund http://www.wcrf-uk.org/

Figure 6 - ‘All cause cancer’ - lack of exercise as an independent risk factor



Source: World Cancer Research Fund - launch presentation November 2007

He felt that if the above forces were not to *'bankrupt'* the NHS, then the whole population would need to have a far better understanding of health determinants, and become far more *'engaged'* in maintaining their own health.

Extrapolating to the year 2022, he predicted three possible scenarios.

- With slow uptake of *'health engagement'*, total UK health spend would rise from 7.5% to 12.5% of GDP.
- *'Solid progress'* would lessen this rise from 7.5% to 11.5% of GDP.
- A *'fully engaged'* scenario would minimise the rise from 7.5% to 10.5%.

Undoubtedly the same pressures apply in Guernsey. We must expect to spend an increasing amount of our GDP on health and healthcare, although whether this should come from Government revenue, personal contributions, or a mixture of both, is still open for debate. We can, however, minimise future healthcare costs by becoming more *'fully engaged'* in the maintenance and protection of our own health.

■ Coping with cancer *(Figure 5 and 6)*

The fall in the most common causes of *'premature death'* has already been summarised in *figure 1*, although it will also be noted that 'all cause cancer' still contributes to the majority of *'potential years of life lost'* in Guernsey.

In November 2007, the World Cancer Research Fund arranged for the simultaneous launch in London, Washington and Hong Kong of a major new publication *'Food, Nutrition, Physical Activity in the Prevention of Cancer'*. This was the result of almost ten years research, and pointed out that *'Cancer is largely a preventable disease'*.

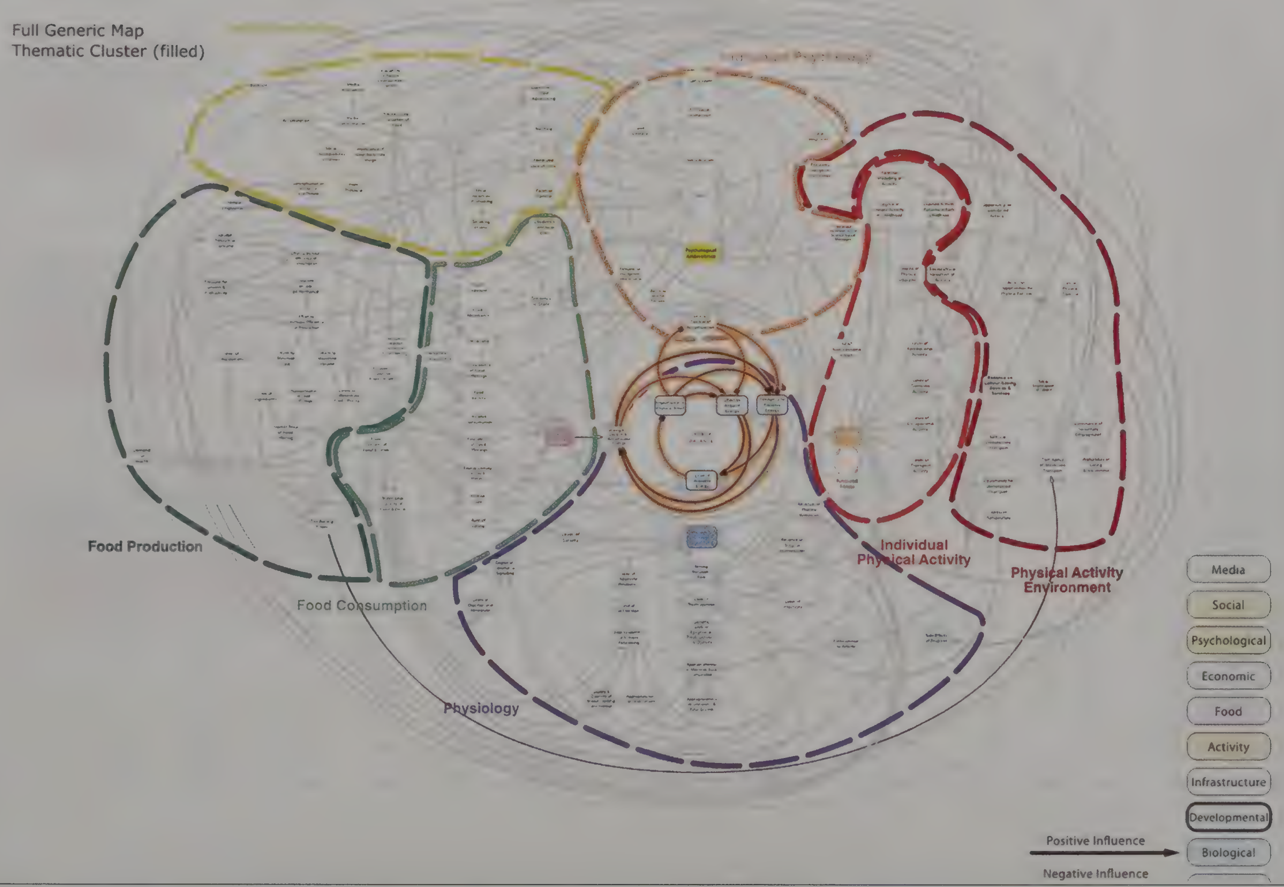
- *35% may be prevented through smoking cessation.*
- *A further 30-40% by appropriate food and nutrition, regular physical activity and avoidance of obesity.*
- *20% through appropriate safeguards with industrial chemicals, radiation, sunshine, etc.*

A summary of their recommendations for reducing the risks of new cancers is shown in *figure 5*.

Figure 6 summarises that the risks of *'all cause cancer'* are more than doubled in the obese, but can be reduced in all groups by remaining *'aerobically fit'*, i.e. being able to demonstrate the pulse rate returns rapidly to normal following vigorous exercise.

Figure 7 - Obesity Thematic Cluster Map

Map 5



Source: Foresight Report *'Tackling Obesities: future challenges'* Government Office for Science 2007

- **The rising challenge of obesity *(Figure 7)***

It has been suggested that *'Obesity is the most significant public and personal health challenge facing us today'.* In June 2007, the Health and Social Services Department brought a Green paper to the States on the need for a *'Nutrition, Exercise and Weight'* Strategy for Guernsey.

Following debate, the States resolved *'to direct the Health and Social Services Department to report back to the States by June 2008 (earlier if feasible) with firm proposals based on the further investigations required, taking into account the views expressed by the States, together with the consultations undertaken with other interested parties and identify the resource implications of the strategy'.*

Guernsey is not alone in its concerns about rising levels of obesity. Since the last States Report, there has been a considerable quantity of new research from both international and national bodies on the health, social and economic consequences of rising levels of obesity, and on those interventions which are likely to be effective in helping to contain and reverse this.

Perhaps the most useful of these Reports (at least from the Guernsey perspective) has been the *'Foresight Report'* produced by the UK Government for Science in October 2007, *'Tackling Obesities: future choices'*.

This points out that the belief that *'if people eat less and did more, then the problem of obesity would be solved'*, is not supported by the available evidence.

In reality, their research found that obesity is the result of complex interactions between an enormous number of factors – or variables, relating to individual biology, dietary habits, levels of physical activity and psychological behaviours. In all, they identified 108 different variables, which they classified in a generic *'thematic cluster map', (figure 7)*. Although individual components may lack clarity, the overall complexity of the various inter-relationships is self evident.

The Guernsey *'Obesity Strategy Group'* have taken a very similar approach. Having reviewed the considerable amount of new research in this field, they have produced a new *'Guernsey Obesity Strategy'* which is presently out for consultation, and the HSSD Minister has now told the States that it is hoped to return for debate no later than November 2008.

As the *'Foresight'* Report acknowledges *'Human biology is ill-equipped to cope with twentieth century lifestyles that are becoming increasingly sedentary and involve dietary abundance'.*

They conclude that *'Obesity is not just a health responsibility, it is a responsibility for the whole government'.*

Global warming: a global challenge

In January 2008, professional leaders, the national media, public health physicians, health economists and doctors from several other disciplines met at the Royal College of Physicians in London for what was described as a landmark conference to address *'Climate change and health'*.

It was proposed and largely agreed by those present that:

- *Increasing global warming is largely the result of human activity and that half the effects of such warming are 'already in the pipeline'.*
- *Escalating climate change will herald plague, pestilence, war, famine and mass migration on a global scale never seen before.*
- *Such health impacts will be greatest in low income countries - those least able to cope with them.*
- *The middle aged amongst us will feel the bite, our children will be savaged, unless we agree to act now.*
- *'That individual actions will be as important as Government measures in making the necessary changes.*
- *That just as doctors had a key role in combating the sanitary and food related diseases of the nineteenth century and the consequences of the smoking epidemic in the twentieth century, so too they have a duty to alert the community, and take a leadership role in helping reduce the health impacts of global warming which now face us during the twenty-first century.'*

The need for action by individuals as well as Governments has also been taken up in Guernsey with the formation of the *Guernsey Climate Change Partnership* in 2007.

An important step forward has been the publication (and wide acceptance) of their major publication *'Planet Guernsey – towards a sustainable future'* to which the Director of Public Health contributed.

This points out that there are a number of simple actions we can all take, which collectively have some prospect of ameliorating the worst consequences of global warming (www.guernsey-society.org.uk/bookshop/ebooks.htm).

Addressing and containing the consequences of global warming could be the greatest public health challenge which humankind has ever faced.

■ Four health challenges

This Annual Report has taken a somewhat far reaching look back to the origins of public health in Guernsey in the closing years of the nineteenth century, and forward to some of the developing health challenges facing both Guernsey and the World more generally.

I feel the four major health challenges facing Guernsey are:

i. To ensure sufficient funding to meet the rising healthcare expectations of an affluent small jurisdiction, with an ageing population and increasing healthcare costs both 'on' and 'off' island.

ii. To more fully promote cancer prevention strategies.

iii. For the States, individual States Departments, the business sector, the community and individuals themselves to accept the reality and risks of rising levels of obesity, and embrace the *'joined up action'* which will be required to contain and reverse this trend.

iv. To accept Guernsey is now part of the global community, and that we both need to make our own small contribution to trying to stem *'global warming'*, or suffer the full consequences of this along with the rest of the World.

■ A common *'package'* of solutions

Paradoxically, there a number of simple actions which everyone in Guernsey can adopt, and which would have a range of *'parallel benefits'* in all four of the above sectors.

These must include:

- Walking and cycling on shorter journeys, rather than taking the car.
- Do *not* smoke, and limit alcohol consumption to the *'safe and sensible'* levels recommended by the '*World Cancer Research Fund'*.
- Reducing the amount of red meat in our diet to no more than 100g ($^1/_4$lb) a day.
- Increasing the amount of food of plant origin, preferably locally grown, *'in season'* and minimally packaged.
- To try and maintain weight within the *'normal'* weight range. Regular exercise can reduce body weight by 1 kg monthly, and is essential for maintaining such weight loss.
- To try and be as *'energy efficient'* as we can in other sectors of our lives.

Conclusions

Improving public health is about relatively small changes on a sufficiently large scale.

The above recommendations may seem over-simplistic to some, or merely sound commonsense to others, depending on their pre-existing point of view.

However, there is very strong evidence that if adopted by a sufficiently large proportion of Guernsey's population, they would.

i. Help restrain rising healthcare costs.

ii. Help to prevent up to 40% of all new cancers.

iii. Slow down and reverse rising trends in obesity.

iv. Demonstrate that Guernsey as a small community was prepared to make its own small contribution to combating the catastrophic effects of global warming.

Simple though the concepts may seem, it will be very difficult indeed to persuade enough people to change their lifestyles on the necessary scale to have the desired cumulative effects.

This is the challenge I leave to my successor, as Guernsey's 10th Medical Officer of Health and second *Director of Public Health*.

Other public health highlights

Public health activities in Guernsey are structured to cover three main *'domains'*, but with a fair degree of *'overlap'* between these. These comprise:

- Health protection
- Health promotion
- The development and quality of clinical services

Achievements during 2007 and work currently in progress are now reviewed by individual Departments.

Environmental Health and Pollution Regulation

- *Introduction of new food hygiene legislation*

  The Department introduced new legislation during 2007 to reflect changes implemented within the UK and EU in 2006, bringing the Bailiwick into line with current best practice. The areas covered are the implementation of food safety management systems, the training of staff and the traceability of foods.

- *Training arrangements with outside bodies*

  These legislative changes have meant that the Department has revised its training role. Arrangements are now in place so that all Level 1 and Level 2 food hygiene training (which covers the requirement for most of the staff employed in the local catering trade) is now carried out either by the College of Further Education, or by Normandie Health and Safety Ltd.

- *New staff*

  Environmental Health practitioners recently employed by the Department have been recruited for their knowledge of the latest food hygiene standards and practices. By using their knowledge and expertise, we aim to ensure consistency of approach.

- *'Housing overcrowding'* standard

  In response to concerns regarding staff accommodation, the Department has developed and consulted on a new *'overcrowding standard'*. This has received the approval of the Health and Social Services Board.

  Discussions and consultations with staff from the Housing Department and other interested parties are continuing regarding a framework to ensure adequate accommodation for workers on short-term licences.

- *Mobile Phone Infrastructure*

A feature of the Department's work during the past year has been the high profile given to potential health and environmental health effects of radiation emissions from mobile phone antenna.

This was mainly prompted by a large number of applications for sites from Airtel-Vodafone, the new third mobile phone operator.

The Department has worked with the Regulator (Office of Utility Regulation) to ensure that an appropriate standard with regard to health concerns is applied.

OUR *website*

- *'Scores on doors'*

The department is currently monitoring the consultation process of the Food Standards Agency in the UK regarding the *"scores on doors"* food hygiene rating schemes.

Such schemes were introduced by local authorities in response to requests under the *Freedom of Information* Act. The current consultation is to agree the format of a National scheme. The Department will consider the appropriateness of operating such a scheme in Guernsey, but changes to current laws would be required before any implementation would be possible.

- *Music Event Noise Standard*

The Department liaised closely with the Police, Jersey's Health Protection Department and organisers of the proposed *'Guernsey Live'* event in 2007 to agree a suitable noise standard for such live music events. The proposed event in Saumarez Park was never held, but when a similar event was proposed for May 2008 at Victoria Avenue, all of the necessary measures were already in place. Only one minor breach of the noise permit was recorded during the running of *'Guernsey Live 2008'*.

Mr John Cook
Director of Environmental Health and Pollution Regulation

Guernsey Live

Communicable disease and infection control

■ *Childhood Immunisation*

Guernsey continues to maintain gratifyingly high levels of childhood immunisation, with 94% completed primary immunisation coverage at 12 months, and an acceptable 90% MMR coverage at 24 months.

During 2007, there were no confirmed cases of rubella, measles or whooping cough, and only one confirmed case of mumps.

■ *Tuberculosis*

The tuberculosis clinic continues to operate monthly, both to trace and assess the contacts of people with TB, and also to immunise those, who by nature of their work or travel, are at particular risk.

Whilst our practice is based on the UK guidance, we have felt that this could be improved in a number of areas and it is now pleasing to find that the UK guidance has changed to reflect our local practice.

An example is that the immunisation of holiday travellers who are staying in countries that have significant tuberculosis, but for relatively short periods of time, and in relatively good conditions, are no longer being recommended to have immunisation.

For the first time in recent years, we have had no confirmed human tuberculosis cases. Whilst this is extremely gratifying and to some extent reflecting the success of our clinics and procedures, we must remain aware that we have a very mobile population, and a lot of people coming to work in Guernsey from abroad.

Procedures at air and seaports are not rigorous in terms of health surveillance but the new International Health Regulations (IHR) to which Guernsey is a signatory require all jurisdictions to review their present procedures and to address any identified differences within the next two years.

It is quite possible that we could still experience significant outbreaks of tuberculosis but continued vigilance and updating of our procedures will minimise this risk.

- *Imported disease*

We have had no serious imported infectious disease, particularly no dysentery and no malaria. This reflects a generally high level of knowledge about malaria prophylaxis, and compliance with these.

- *Food poisoning*

Food poisoning notifications continue to run at too high a level and there has been a rise from 160 cases in 2006 to 230 in 2007.

A lot of this rise was due to a form of Salmonella, which is known to be associated with eggs and chickens.

A lot of work continues in reminding caterers of the risk of whole shell egg and the importance of using pasteurised egg and of cooking egg products properly.

Further surveillance measures on chickens and eggs, with the help of the Commerce and Employment Department, are planned and this, together with public education, will hopefully both identify and eliminate risky foodstuffs and continue to reinforce education on the appropriate use of raw animal products.

Dr Brian Parkin
Deputy Medical Officer of Health

Infection Control

Our two locally based Infection Control nurses, well supported by the microbiology staff at the Princess Elizabeth Hospital, our local Consultant Pathologist, and the excellent visiting and contracted services from the Birmingham Heartlands NHS Trust, help to ensure that local levels of hospital acquired infection remain a fraction of those reported in the NHS.

In addition, our pro-active approach means that the scope of infection control extends beyond the hospital and into the community, including nurseries, and pre-schools, nursing and residential homes, and to the work place.

Achievements during 2007 include:

- *Infection control policies*

  We currently have seventeen 'updated' infection control policies with one still in development.

- *Infection control leaflets*

  There are now sixty three infection control leaflets, which have proven extremely popular with both patients and staff alike.

- *Clinical pathways*

  Clostridium difficile and *MRSA* Pathways have been developed to ensure that staff are aware of procedures to be followed when caring for patients with these conditions.

- *Pandemic influenza planning*

  Our plans to help ensure Guernsey is well prepared to deal with a predicted global pandemic of influenza continue, with the stockpiling of necessary supplies, training of staff, and contingency plans to continue to be able to provide necessary clinical services against a background of increased demand and decreased staff availability.

- *Infection control audits*

  Annual infection control 'ward audits' continue on hospital wards and in nursing and residential homes. These take approximately one hour and cover many aspects of infection control such as the environment, hand washing, and infection control procedures.

- *Induction and annual mandatory 'infection control' training*

  This is offered to all staff throughout the HSSD, and continues to raise awareness of infection prevention and control for all staff.

Work in progress:

- *Dress Code Policy*

  Development of a *Dress Code Policy* for HSSD will cover aspects such ensuring sleeves are above the elbow prior to hand washing, and that staff have adequate changing facilities.

- *'Infection Control' intranet site*

  This is under development and will include policies, information leaflets, training sessions and link nurse minutes. This will prove to be an effective medium for supplying up-to-date information to all specialities throughout HSSD.

- *New policies under development*

  Currently two policies regarding *'central line'* access and *'peripheral line'* access are being developed. These policies will require collaboration with the link nurses before they are able to be implemented fully as there will be considerable changes from current practice.

  The policies have been developed following EPIC (Evidence based Policies in Infection Control) templates, with the ultimate aim of reducing healthcare acquired infection following central or peripheral line insertion.

- *MRSA Screening Strategy*

  Development of a hospital wide MRSA screening strategy for the future of HSSD services, with the ultimate aim being to reduce healthcare acquired MRSA.

Mrs Elaine Burgess
Lead Infection Control Advisor

Sexual Health Clinic

A high level of activity and service continues to be provided by the *Sexual Health Clinic* located at the *'Orchard Centre'* St Martins.

These premises will, however, be required for other purposes during 2009, so the Sexual Health Clinic will need to be relocated. Arrangements for this are in hand.

Achievements during 2007 include:

- *The Sexual Health Review*

  This was completed by visiting consultant Dr David White in April 2007, and has endorsed the establishment of a combined *Contraceptive and Sexual Health* (CASH) Clinic. Considerable progress has been made over the past year to develop a combined approach to patient care.

- *Hepatitis C treatment*

  There are now believed to be around 100 patients in Guernsey known to have tested positive for Hepatitis C virus (HCV). The Guernsey Hepatitis C treatment programme began treating patients for Hepatitis C in January 2008. Ten patients are currently undergoing treatment, with this number likely to increase by a further 50% by the end of the year.

  The *'on-island'* treatment programme has allowed the more effective management of HCV-infected patients in Guernsey.

  The programme has now been extended to the Guernsey Prison Service, with two patients receiving their treatment whilst in prison.

- *Combined clinic linked to the Hepatitis C treatment programme*

  Linked to the Guernsey Hepatitis C treatment programme is the development of a Combined Clinic with Consultants and Clinical Nurse Specialists from a recognised national and international centre of excellence, at The Royal Free Hospital in London.

  This enables HCV-infected patients to access expert opinions on-Island and allows for the effective delivery of the treatment programme. It also provides staff with on-Island training opportunities.

- *Sexually Transmitted Infection Foundation (STIF) Course*

  The first STIF Course took place in January 2008, was well attended by both doctors and nurses, and received excellent reviews. A further course is planned for 2009.

- *HIV/AIDS*

  There are also believed to be around 20-24 patients who are HIV positive or suffering from AIDS in Guernsey at any one time, and due to improvements in care, their survival is also increasing.

  Such improvements have included changes in antiretroviral therapy and improved monitoring in line with recent changes in the UK and Europe.

The *Multidisciplinary Combined Clinics* with Consultants from University College London and St Thomas' Hospital continue to ensure that patients in Guernsey receive a high standard of care. These clinics also contribute to on-island training and education, and have been attended by nurses and GPs from outside the Sexual Health Service.

- *HIV awareness*

  Efforts continue to be made to raise awareness of HIV, its mode of spread and effective prevention. These have included newspaper, television and radio interviews, particularly centred around World AIDS Day on 1st December.

- *Sexual Health Co-ordinator*

  A Sexual Health Co-ordinator has now been appointed. This key post will help support the further development of the contraceptive and sexual health service, and will enhance the level and quality of care offered to people living in Guernsey.

Work in progress

- *Links with other services*

  Links will continue to be developed with Primary Care, the Medical Specialist Group, the Community Mental Health Service and Drug Concern to enhance the multidisciplinary approach to patient care.

- *Protocols for sexual health screening and treatment*

  These will continue to be developed on an island-wide basis.

- *Ongoing audit programme*

  Various aspects of sexual health services are now subject to regular audit to ensure and maintain high quality standards.

Dr Nicola Brink
Sexual Health Physician

Guernsey Family Planning Service

- The Guernsey Family Planning Service is one of the several *'arms length'* services funded by an annual grant from the HSSD, administered through the Public Health and Strategy Directorate.

- The number of new clients seen annually appears to have peaked at 430 in 2003, and then settled at around 360 per annum for several years, before showing a further upward trend in the early part of 2008.

- The total number of attendances continues to increase, and has shown a threefold increase over the past ten years to 2,457 in 2007.

- The range of services offered by the Guernsey Family Planning Service continues to expand, and it is now offering sexual health screening for women and asymptomatic men. They are also now open for 23 hours per week including Saturdays.

- The most recent data (September 2007) confirm that.

    - Adolescent contraception rates (births and terminations <20 years) have remained relatively stable over the past eight years.

    - They are only around 40% of comparable rates in England.

    - Although there has been a steady upward trend of total abortions performed on and off island, the huge escalation in abortion numbers predicted by some opponents has not yet occurred, and indeed showed a slight decline in 2007.

    - Abortions to women <20 years have not contributed to this generally upward trend.

- On balance, it must be concluded that the additional funding to the Guernsey Family Planning Service has been well invested and the clinic should be commended on its successful contribution to our low teenage conception rate locally.

- There is a large amount of evidence to show that adolescent mothers generally have greater difficulty in coping, suffer more social and health problems, whilst their offspring suffer more ill health.

- In return for a fairly modest investment in the Guernsey Family Planning Service budget, far greater amounts in health and social costs have been saved.

Mrs Sue Le Page
Guernsey Family Planning Service, Manager

States Analyst's Laboratory

Accreditation in Quality Assurance

In June 2007, the Laboratory was visited by representatives from the United Kingdom Accreditation Service to audit the laboratory's quality assurance system. Again no serious defects were found, the Audit proceeded very well with the Assessors being very complimentary about the Laboratory's quality system.

Workload

The Laboratory's work consists of two main areas, - water supply and environmental contamination. Police and Customs work forms a minor part of the Laboratory's total workload, although it is a large portion of the workload of the States Analyst - who personally carries out all alcohol and most drugs analyses for the Police and Customs.

The Laboratory workload is calculated by applying a *'difficulty factor'* to each sort of analysis performed and multiplying the number of each type of analysis by this factor.

Using this scale, laboratory workload increased from 50,082 *'units'* in 2001, reaching a peak of 54,005 *'units'* in 2004, with a slight decline to 52,910 in 2007.

Staffing

In 2007, one staff member resigned and another was taken on.

The future

During 2008, the Laboratory intends to introduce testing for Legionella in water. This is likely to be a significant amount of work.

A new directive on bathing water quality is likely to be introduced in 2012 and this will also impact on the laboratory's workload in the future.

Dr David Mortimer
States Analyst

Major Incident Plan

All hospitals have a responsibility to ensure that they are able to deal with a larger than usual number of sick or seriously injured patients arriving within a short period of time.

Possible scenarios in Guernsey might include an aircraft incident at the airport, a hotel fire, a ferry stranding or sinking, or a multiple vehicle *'pile up'*.

Guernsey's *Major Incident Plan* has undergone a number of significant changes and revisions over the past few years, but even the best *'Major Incident Plan'* is likely to fail unless it is properly tested. The first *'Livex'* (live exercise) to actively involve the hospital in over a decade was held in June 2008, with observers from the St John Ambulance and Rescue Service, Jersey Ambulance, Island Police and the States Emergency Planning Officer.

All were impressed by how well the various components of the Plan worked in practice, and although there still a degree of *'fine tuning'* to be achieved, residents of Guernsey can now be reassured that our *Major Incident Plan* has been tested, and that it does demonstrate that the Princess Elizabeth Hospital appears well prepared to cope with such an eventuality.

Health Promotion Unit

- *Happy 20th Birthday:*

In February the Unit celebrated its 20th birthday. An open day and display of old photographs and press articles gave everyone the opportunity to reminisce, whilst reflecting on past successes.

- *NEWS (Nutrition Exercise and Weight Strategy)*

The *Nutrition Exercise and Weight Strategy* was accepted by the States as a Green paper in June 2007 and the HSSD was instructed to return with more detailed proposals.

Former Health Promotion Officer Lucy Whitman was appointed as the Project Officer and has completed many hours of research into all the latest findings on obesity.

Her work has resulted in a new Guernsey *Obesity Strategy* which was accepted by the HSSD, and is currently out for consultation with other States Department and organisations for comment.

- *The 'Walk your Way to Health' Programme*

This continues to go from strength to strength with up to 20 to 30 walkers on some days and a group of new leaders trained to guide the walkers.

In June 2008 the scheme was awarded accreditation by the UK *'Walking the Way to Health'*, a joint initiative between Natural England and the British Heart Foundation in the UK.

- *Guernsey Quitline*

  Guernsey Quitline has seen one of its busiest year to date and there has been a steady stream of clients throughout the year. Many chose to stop following the ban on smoking in the workplace that came into force in 2006. The arrival of the new smoking cessation drug *Champix* has also resulted in many more clients successfully stopping smoking.

- *Young People's Survey*

  In October, in conjunction with the Education Department, the Unit published the results of the *Young Peoples Survey*.

  This comprehensive report outlined the views of nearly 2000 Guernsey youngsters on all aspects of health, ranging from healthy eating to smoking and bullying.

  The results have been presented to many different groups and agencies, and used by schools themselves to review their own health education programmes.

- *Primary Schools Congress*

In May 2008, nearly 160 primary school children used the results when they put forward their own views on how the issues could be taken forward.

This *Primary Schools Congress* was sponsored by Specsavers and was hailed as a great success by all involved.

In particular many of the seventeen Deputies who participated were most impressed by the ideas brought forward by the young people, and the quality of their debate.

- *Mental health promotion*

  This was an area tackled in depth for the first time. Activities included making links with the Mental Health Service, training days for teachers and workplaces and developing a programme called *'Relax and feel the balance'* with the aim of preventing stress related issues from becoming more serious health problems.

- *Island Tobacco Strategy 2009-2013*

  Work to support the drafting of a new *Island Tobacco Strategy 2009 - 2013* was carried out in the months preceding its acceptance by the States in March 2008.

  Many hours were also spent working with the Jersey Health Promotion Unit and the Law Officers to firstly consult the public on pictorial pack warnings for cigarette packs, and then to draw up the legislation to enable this to happen. This should take place towards the end of the year.

Work in progress

- *Progressing the 'Tobacco Strategy'*

  The remaining recommendations of the Tobacco Strategy now need to be implemented. The first of these will be supporting the staff and inmates at the States Prison to enable the building to become *'Smokefree'* during 2009, and to support mental health staff to enable them better assist their clients to stop smoking.

- *Corporate Anti-Poverty Programme (CAPP)*

  A new limited tenure Health Promotion Officer post has been created through funding from the Corporate Anti Poverty Programme. The successful candidate will research and develop activities to help to reduce the health inequalities found on the island, particularly by promoting better *'health literacy'* amongst the less affluent.

- *'Health Trainer' Scheme*

  In conjunction with the College of Further Education, the Health Promotion Unit has set up a course to provide qualified Health Trainers.

  This new programme from the UK has proved to be very successful in helping individuals to obtain health advice and support, and enabled them to make changes to the their health behaviours. The first trainers will qualify in July 2009.

Miss Yvonne Le Page
Health Promotion Manager

Healthcare Information Unit

Achievements during 2007

- The Unit continues to improve its cancer data collection by now digitally sending *'deaths information'* to the South West Public Health Observatory.
- Year on year, data collection is also improving, along with the accuracy of the reports now being transmitted to the Observatory.
- Monthly management information was upgraded and expanded during 2007, particularly in the production of data for critical care wards.
- Much of this year has been dominated by preparations for the EHSCR. The analysts have been working hard to produce data sets for migration across to the new system. One analyst was also seconded to the EHSCR team for a period of six months.
- Work has continued on *'off-island placement'* and *'reciprocal health analysis'*. Data is now routinely collected from various UK Trusts, but is analysed locally to define trends. This year, costing analyses were also produced and related to the NHS *'National Tariff'*.
- Comprehensive Service Review data was also produced for each of the Service Reviews that took place in 2007.
- The collection of deaths data from the Greffe has been considerably improved, resulting in the data being more timely and of improved quality.

Work in progress 2008

- The analysts have now completed the work to commence the collection of cancer staging data.
- This along with the improved deaths information should enable the Public Health Observatory to begin providing data on cancer survival, which will be of real benefit in comparing local results with those achieved elsewhere.
- The *Healthcare Information Unit* has also been working with the Reciprocal Health team to try and gain direct access to *'Commissioner Code'* data for Guernsey.

- This should enable a direct data link with NHS patient activity data, so that any information relating to any local patient being treated away from the island can then be adequately analysed. This should allow a far more comprehensive view of patient care, and will be invaluable with respect to budgeting for future spending.

Mrs Helen Jones
Mrs Jenny Elliott
Healthcare Information Analysts

Clinical Audit

- *'Drop in' Sessions*

  Local initiatives have been implemented to revitalise and reinvigorate clinical audit. Clinical audit *'drop-in'* sessions were held in a variety of sites across the Health and Social Services Department, including in Alderney. Many ideas for clinical audit projects were discussed, and a number of these audits are currently being completed.

- *Information leaflet and Internet site*

  The clinical audit *'information leaflet'* and *'intranet site'* have been revised and updated. Copies of the leaflet have been provided to all staff.

  The intranet pages now have a new layout, with links to online learning resources.

  A Clinical Audit Diary section to keep staff updated on clinical audit activity, locally and nationally has also been developed. The results of national clinical audit projects in which we have participated are also available online, as well as copies of the current and past Clinical Audit Annual Reports.

- *Clinical governance skills*

  A survey on clinical governance skills amongst the Allied Health Professions and Nurses revealed a good awareness of Clinical Governance.

  Our new 20-credit course on clinical audit in health and social care will help staff to develop their skills. The course is being run by the Clinical Audit Department in conjunction with the Institute of Health and Social Care Studies. Feedback from the first group of students has been very positive.

- *New Clinical Audit Awards*

  This year, we have launched the first Guernsey Clinical Audit Awards, sponsored by the *Insurance Corporation of the Channel Islands*, which will see the two best clinical audit projects receiving worthwhile prizes.

Publicity regarding the awards created a lot of interest and has resulted in a lot of good audit activity involving service users across the Health and Social Services Department.

- *Participation in National Audits*

With considerable input from Clinical Audit Department staff, Guernsey now participates in a growing number of national clinical audit projects.

Current national projects include the *National Sentinel Audit of Stroke, Chronic Obstructive Pulmonary Disease* (COPD), and the *Myocardial Ischaemia National Audit Project* (MINAP).

It is useful for Guernsey to compare our results to those of the best centres nationally and with those from the other islands.

Earlier this year the Jersey Breast Screening Team visited Guernsey's Breast Screening Unit. We look forward to working jointly with the Jersey audit team on breast cancer screening and in other related cancer outcomes during the coming year.

- *Cognitive Pain Management Programme*

Locally, the nurse-led *Cognitive Pain Management Programme* shows that patients with chronic pain who complete the programme achieve improvements in movement, active coping and disability levels.

Readmission to hospital within 28 days is now being audited.

A number of *multidisciplinary nutrition audits* are also in progress, with extensive service user involvement.

The *Continence Service* is also auditing referrals with a view to producing updated referral guidelines and managing their caseload more effectively. Allied Health Professionals' participation in audit continues to grow.

- *'Closing the Loop'*

Our 2007 report *"Closing the Loop"* showed that, in 2006, two-thirds of audit recommendations were implemented, and many more were being followed up.

In the coming months, we will provide individualised feedback to each auditor on the quality of their audit, using our new standardised audit assessment tool. Increasing emphasis will be placed on action-planning to enable implementation of audit recommendations.

- *Future Plans*

The purpose of clinical audit is to improve the overall standard and quality of care that a service user receives.

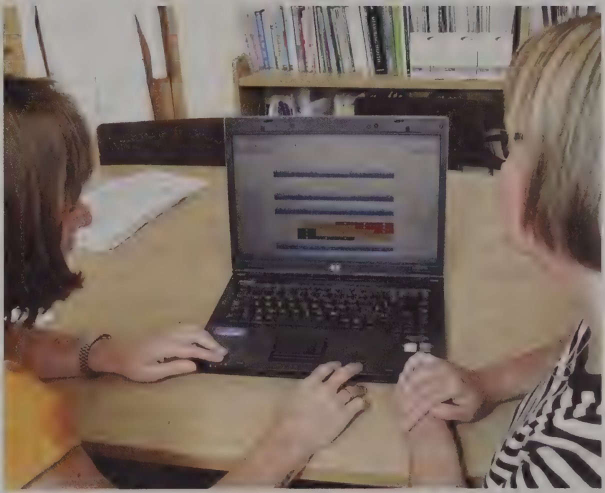
In the coming year, we will develop a new strategy for clinical audit across the Health and Social Services Department. This will facilitate the development of audit programmes to address priorities within each Directorate, Department and Unit.

Clinical audit requires time and resources, both for the initial analysis and for the implementation of change. The new strategy must promote a culture of clinical and social care audit, supported at all levels within the organisation.

Miss Eithne Downey
Mr Brian O'Connell
Clinical Audit Nurses

Clinical Risk

The management and learning from clinical risk incidents within HSSD has seen some recent changes, with the new HAQU (Health Accreditation Quality Unit) standards for clinical risk management proving a firm base upon which to develop these new initiatives.



Throughout the year, we have established:

- *Quarterly reports* to the Joint Clinical Governance Committee which now detail all reported *Serious Untoward Incidents* (SUI), which are those having a risk rating greater than 12, and deemed to be *'High Risk'*.
- The inclusion of some of the less obvious areas of practice within the clinical risk management structure, with the formation of 5 new *Clinical Risk Management Committees*, bringing the total to 13.
- The implementation of *Root Cause Analysis* to investigate any *Serious Untoward Incident*, with a written report circulated to all parties involved in the incident. Learning points are then fed-back to the clinical risk management committee to action.

- *Improved communication* between the HSSD and the MSG with regular meetings between the Clinical Risk Manager, the HSSD contracts manager and the MSG chief executive.

- *Improved links with corporate governance*, with the Clinical Risk Manager now attending regular monthly meetings.

- The need for *Serious Untoward Incidents* to be investigated by a senior clinician, not from the department involved in the incident, is required by the HAQU standards, and has now been agreed. It is hoped that this will now progress, with the establishment of a formal SUI Panel.

- A generic organisation-wide incident *'reporting form'*, to comply with HAQU standards, is now being developed. The natural progression to electronic incident reporting is also ready to be implemented.

- *Annual reports* for each service area, which show the number of incidents reported and the percentage of those deemed to be SUIs, as well as the main cause groups for such incidents.

Clinical risk management within the HSSD has evolved considerably from a *'blame culture'*, to a more open and honest appraisal of what went wrong and how can we learn from this in order to avoid a recurrence.

There are, however still areas where further progress needs to be demonstrated. These include:

- The *SUI* Panel, chaired by the *Professional Head of Nursing and Midwifery*, and comprising a core group including the Clinical Risk Manager and representation from the MSG.

- The roll out of *electronic incident reporting* throughout all sites in the HSSD, which will allow managers and the Clinical Risk Manager to be aware of any incidents as they are reported.

- Training in clinical risk assessments for all staff, in order to address potential risks early and implement measures to reduce those which can be avoided.

- A change in title from *'Clinical Risk Manager'* to that of *'Patient Safety Manager'*, to be more in-line with their UK counterparts, and to demonstrate that their role is primarily one of ensuring safe patient care.

The Clinical Risk Manager has traditionally been a *"jack of all trades"*, which has impacted on the time available to progress risk management throughout the organisation. This is slowly being addressed, through agreement to sanction the following posts:

- Quality liaison to improve the production, availability and access to local policies, procedures and guidelines, and to ensure they meet the required criteria as set by HAQU and the Chief Officer.

- *Medical Equipment Training Officer*, which not only is a requirement of the Health and Safety Executive, but would also considerably reduce the number of equipment related incidents related to inadequate training in the use of these. This often results in an increased workload for the EBME department to repair the equipment, or increased costs to the HSSD to replace the damaged equipment.

Overall it can now be demonstrated that clinical risk management is firmly embedded within the overall governance structures of the HSSD.

Mrs Lynn Lewendon
Clinical Risk Manager

Health Records Department

Achievements 2007

- The Health Records Department continues to meet its obligations to prepare, store and transport health records around the Princess Elizabeth and Castel Hospitals, on time and within budget.
- The Department continues to operate 24 hours a day, every day of the year, for the secure storage and retrieval of operational and archived medical records.
- Consultant produced operation notes, discharges and clinic summaries are processed at a rate which exceeds the *'contract'* performance criteria.
- Introduction of a resource planning tool, using existing software, has been implemented which covers all staff in the Health Records department. This tool enables better management of the department by allowing easier planning and monitoring of flexible working patterns and aids communication amongst staff.
- Recording and monitoring of work allocated amongst the clerks assists in providing fairer working practices.
- Streamlining of health record releases has led to the saving of a secretarial post and also ensures that authorised releases are performed within the required number of days.

TheWork in Progress and Challenges 2008

- The Health Records Department has for a number of years suffered from a severe shortage of space. Due to the continuing growth in the number and size of health records, this is becoming an increasing problem. Plans have been drawn up to expand storage, but this needs to occur against an overall shortage of space across HSSD premises.

- Interim measures urgently need to be taken prior to the completion of Phase 5 building development and the introduction of the Electronic Health and Social Care Record to alleviate these serious storage problems.

- Recruitment of clerks able to work full-time remains problematic and as a result more part-time, rather than full-time staff are being employed. This is being addressed during recruitment whenever possible.

- The implementation of the new *Electronic Health and Social Care Record* will have a number of significant challenges for the Department over the next few years. It will also have an impact on most areas of existing work practices.

Mr Michael Holland
Health Records Transition Manager

Clinical Coding

One of the most important but least recognised aspect of the Public Health Directorate's work is the need to ensure accurate healthcare information, based on reliable and timely clinical coding.

This function continues to be extremely well provided by our two clinical coders, Mrs Margaret Cann and Mrs Sue Cockayne whose important work deserves to be more widely recognised.

Vital Statistics 2007

Births and birth-related data

	Guernsey		England & Wales
	2007	5 Year Mean 1999-2003	2004
Estimated mid year resident population:	60,309*	59,807	53,050,000
• males	29,568*	29,138	25,990,000
• females	30,741*	30,669	27,060,000
• M : F	0.96	0.95	0.96
Population density/Km² [Area 63.1Km²]:	956	950	51.9
Marriages:	331	349	246,459
• marriages/000	5.5	5.84	4.7
Divorces:	138	173	153,199
• divorces/000	2.3	2.9	2.9
Divorces : Marriages	0.42	0.5	0.62
Live birth registrations:	645	624	639,724
• males	350	321	328,340
• females	295	304	311,381
• M : F	1.19	1.05	1.05
Births outside marriage:	258	205	269,724
• % all births	40%	33%	42.2%
Stillbirths:	4	2.6	3,686
• Rate/000 live births	6.2	4.2	5.8
Infant deaths:(<1 year)	5	2.8	3,400
• infant death rate/000 LB	7.8	4.5	5.3
Crude Birth Rate/000	10.6	10.4	12.1
Natural increase per annum:	+0.21%	+0.20%	+0.49%

* includes *'natural increase'*, but excludes net migration

Vital Statistics 2007

- **Deaths and death-related data** (By ICD 10 Codes)

	Guernsey		England & Wales
	2007	5 Year Mean 1999-2003	+2004
Total deaths: (number)	517	557	512,571
• males	260	264	244,130
• females	257	296	268,411
• M : F	1.01	0.88	0.91
Crude death rate:/000	8.3	9.3	9.7
Circulatory deaths (I00-I99): No	164	200	198,603
• males - rate/00,000	291	322	382
• females - rate/00,000	254	347	367
Cancer deaths (C00-C97/D00-D48):	130	128	134,856
• males - rate/00,000	240	240	271
• females - rate/00,000	192	191	238
Lung cancer deaths (C34): No	25	26.4	28,328
• males - rate/00,000	54	54	65
• females - rate/00,000	29	35	42
Breast cancer deaths (C50): No	11	7	10,972
• females - rate/00,000	36	22.8	41
Alcoholic liver disease and cirrhosis (K70) (K74): No	4	1.2	6,751
• males - rate/00,000	6.8	2.1	16.1
• females - rate/00,000	6.5	2.0	9.5
Injury deaths (S00-X59) (including suicide): No	11	9	16,497
• males - rate/00,000	27	21.3	39
• females - rate/00,000	9.8	9.8	24
Suicide deaths (X60-X84): No	3	3	3,313
• males - rate/00,000	6.8	8.2	9.7
• females - rate/00,000	3.3	2.0	3.0

Note: Outstanding inquest on the death of one female aged 25-44 years, and cause of death therefore remains ‘unclassified’

+Source: OHE *‘Compendium of Health Statistics’* (18th Edition 2007)

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2007

ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group I Infectious and parasitic diseases																	
A41	Other septicaemia	0	0	0	0	0	0	0	1	1	1	2	2	1	8	**4**	**12**
Total Group I		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**2**	**2**	**1**	**8**	**4**	**12**
Group II Neoplasms																	
C15	Malignant neoplasm of oesophagus	0	0	0	0	0	0	0	0	0	1	1	0	2	1	**3**	**2**
C16	Malignant neoplasm of stomach	0	0	0	0	0	0	0	0	0	0	0	0	4	3	**4**	**3**
C18	Malignant neoplasm of colon	0	0	0	0	0	0	1	0	1	2	2	0	4	3	**8**	**5**
C19	Malignant neoplasm of rectosigmoid junction	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**	**0**
C20	Malignant neoplasm of rectum	0	0	0	0	0	0	0	0	1	0	1	0	2	1	**4**	**1**
C25	Malignant neoplasm of pancreas	0	0	0	0	0	0	0	0	2	1	1	3	1	1	**4**	**5**
C26	Malignant neoplasm of other and ill-defined digestive organs	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
C32	Malignant neoplasm of larynx	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
C34	Malignant neoplasm of bronchus and lung	0	0	0	0	0	0	0	0	4	0	4	3	8	6	**16**	**9**
C38	Malignant neoplasm of heart, mediastinum and pleura	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
C43	Malignant melanoma of skin	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
C45	Mesothelioma	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**0**
C50	Malignant neoplasm of breast	0	0	0	0	0	0	0	1	0	3	0	2	0	5	**0**	**11**
C53	Malignant neoplasm of cervix uteri	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
C56	Malignant neoplasm of ovary	0	0	0	0	0	0	0	0	0	0	0	1	0	3	**0**	**4**
C61	Malignant neoplasm of prostate	0	0	0	0	0	0	0	0	0	0	0	0	10	0	**10**	**0**
C64	Malignant neoplasm of kidney, except renal pelvis	0	0	0	0	0	0	0	0	0	0	0	0	0	2	**0**	**2**
C67	Malignant neoplasm of bladder	0	0	0	0	0	0	0	0	0	0	0	0	4	3	**4**	**3**
C71	Malignant neoplasm of brain	0	0	0	0	0	0	1	0	1	0	0	0	1	0	**3**	**0**
C78	Secondary malignant neoplasm of respiratory and digestive organs	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
C79	Secondary malignant neoplasm of other sites	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
C80	Malignant neoplasm without specification of site	0	0	0	0	0	0	0	0	1	1	1	0	2	4	**4**	**5**
C85	Other and unspecified types of non-Hodgkin's lymphoma	0	0	0	0	0	0	0	0	0	0	0	0	1	1	**1**	**1**

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		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
C90	Multiple myeloma and malignant plasma cell neoplasms	0	0	0	0	0	0	0	0	0	0	0	0	1	1	**1**	**1**
C91	Lymphoid leukaemia	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
C92	Myeloid leukaemia	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
D32	Benign neoplasm of meninges	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
D43	Neoplasm of uncertain or unknown behaviour of brain and central nervous system	0	0	0	0	0	0	0	1	0	0	0	0	1	0	**1**	**1**
D44	Neoplasm of uncertain or unknown behaviour of endicrine glands	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**1**
Total Group II		**0**	**0**	**0**	**0**	**0**	**0**	**3**	**2**	**14**	**9**	**11**	**10**	**43**	**38**	**71**	**59**
Group IV **Endocrine, nutritional and metabolic diseases**																	
E34	Other endocrine disorders	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
Total Group IV		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**
Group V **Mental and behavioural disorders**																	
F03	Unspecified dementia	0	0	0	0	0	0	0	0	0	0	0	1	3	10	**3**	**11**
Total Group V		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**3**	**10**	**3**	**11**
Group VI **Diseases of the nervous system**																	
G20	Parkinsons disease	0	0	0	0	0	0	0	0	3	0	0	0	1	0	**1**	**0**
G31	Other degenerative diseases of nervous system, not elsewhere classified	0	0	0	0	0	0	0	0	1	0	0	0	1	1	**1**	**1**
G35	Multiple sclerosis	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
G40	Epilepsy	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
Total Group VI		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**3**	**2**	**3**
Group IX **Diseases of the circulatory system**																	
I11	Hypertensive heart disease	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**

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		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
I21	Acute myocardial infarction	0	0	0	0	0	0	0	1	1	0	2	2	10	9	**13**	**12**
I22	Subsequent myocardial infarction	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
I25	Chronic ischaemic heart disease	0	0	0	0	0	0	0	0	0	0	2	1	6	4	**8**	**5**
I26	Pulmonary embolism	0	0	0	0	0	0	0	0	2	0	0	0	3	4	**5**	**4**
I31	Other diseases of pericardium	0	0	0	0	0	0	0	0	0	0	0	0	1	1	**1**	**1**
I33	Acute and subacute endocarditis	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
I35	Nonrheumatic aortic valve disorders	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
I38	Endocarditis, valve unspecified	0	0	0	0	0	0	0	0	0	0	0	0	0	2	**0**	**2**
I42	Cardiomyopathy	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
I46	Cardiac arrest	0	0	0	0	0	0	1	0	1	0	0	0	5	4	**7**	**4**
I49	Other cardiac arrhythmias	0	0	0	0	0	0	0	0	1	0	1	0	0	1	**2**	**1**
I50	Heart failure	0	0	0	0	0	0	1	0	0	0	7	1	22	17	**30**	**18**
I60	Subarachnoid haemorrhage	0	0	0	0	0	0	0	0	1	0	1	0	0	2	**2**	**2**
I61	Intracerebral haemorrhage	0	0	0	0	0	0	0	0	0	0	1	0	0	1	**1**	**1**
I63	Cerebral infarction	0	0	0	0	0	0	0	0	1	0	0	0	0	1	**1**	**1**
I64	Stroke, not specified as haemorrhage or infarction	0	0	0	0	0	0	0	0	0	0	0	0	7	19	**7**	**19**
I66	Occlusion and stenosis of cerbral arteries, not resulting in cerbral infarction	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
I67	Other cerebrovascular diseases	0	0	0	0	0	0	0	0	0	0	0	0	3	2	**3**	**2**
I71	Aortic aneurysm and dissection	0	0	0	0	0	0	0	0	0	0	0	1	2	2	**2**	**3**
I72	Other aneurysm	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
Total Group IX		**0**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**7**	**0**	**14**	**5**	**63**	**72**	**86**	**78**
Group X																	
Diseases of the respiratory system																	
J18	Pneumonia, organism unspecified	0	0	0	0	0	0	0	0	1	2	5	1	21	20	**27**	**23**
J22	Unspecified acute lower respiratory infection	0	0	0	0	0	0	0	0	0	0	0	0	1	2	**1**	**2**
J44	Other chronic obstructive pulmonary disease	0	0	0	0	0	0	0	0	0	0	3	1	8	6	**11**	**7**
J69	Pneumonitis due to solids and liquids	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
J84	Other interstitial pulmonary diseases	0	0	0	0	0	0	0	0	1	0	0	0	1	2	**2**	**2**
J86	Pyothorax	0	0	0	0	0	0	0	0	0	1	0	0	0	0	**0**	**1**
J96	Respiratory failure, not elsewhere classified	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
J98	Other respiratory dosorders	0	0	0	0	0	0	0	0	0	0	0	1	0	1	**0**	**2**
Total Group X		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**3**	**8**	**3**	**32**	**31**	**43**	**37**

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ICD10 Code	Cause of Death	Age Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+		Age All Ages	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group XI **Diseases of the digestive system**																	
K22	Other diseases of esophagus	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
K26	Duodenal ulcer	0	0	0	0	0	0	0	0	0	0	0	0	0	2	**0**	**2**
K52	Other noninfective gastroenteritis and colitis	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
K55	Vascular disorders of intestine	0	0	0	0	0	0	0	0	0	0	1	1	0	4	**1**	**5**
K57	Diverticular disease of intestine	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
K63	Other diseases of intestine	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**0**	**1**
K65	Peritonitis	0	0	0	0	0	0	0	0	0	0	0	0	2	2	**2**	**2**
K70	Alcoholic liver disease	0	0	0	0	0	0	2	0	2	0	0	0	0	0	**4**	**0**
K72	Hepatic failure, not elsewhere classified	0	0	0	0	0	0	0	0	0	1	1	0	1	0	**2**	**1**
K74	Fibrosis and cirrhosis of liver	0	0	0	0	0	0	0	0	0	0	2	0	0	0	**2**	**0**
K75	Other inflammatory liver diseases	0	0	0	0	0	0	0	1	0	0	0	0	0	1	**0**	**1**
K85	Acute pancreatitis	0	0	0	0	0	0	0	0	0	0	0	1	1	0	**1**	**1**
K92	Other diseases of digestive system	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
Total Group XI		**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**1**	**4**	**4**	**5**	**11**	**13**	**16**
Group XII **Diseases of the skin and subcutaneous tissue**																	
L03	Cellulitis	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
L08	Other local infections of skin and subcutaneous tissue	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
L97	Ulcer of lower limb, not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
Total Group XII		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**1**	**2**	**1**
Group XIV **Diseases of the genitourinary system**																	
N17	Acute renal failure	0	0	0	0	0	0	0	0	1	0	0	0	3	3	**4**	**3**
N18	Chronic renal failure	0	0	0	0	0	0	0	0	0	0	1	0	3	0	**4**	**0**
N19	Unspecified renal failure	0	0	0	0	0	0	0	0	0	0	1	0	4	2	**5**	**2**
Total Group XIV		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**0**	**10**	**5**	**13**	**5**

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		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group XVI Certain conditions originating in the perinatal period																	
P95	Fetal death of unspecified cause	3	1	0	0	0	0	0	0	0	0	0	0	0	0	**3**	**1**
Total Group XVI		**3**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**1**
Group XVII Congenital malformations, deformations & chromosomal abnormalities																	
Q28	Other congenital malformations of circulatory system	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**
Total Group XVII		**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
Group XVIII Symptoms, signs & abnormal clinical & laboratory findings, not elsewhere classified																	
R09	Other symptoms and signs involving the circulatory and respiratory systems	0	0	0	0	0	0	2	0	0	1	0	0	1	0	**3**	**1**
R19	Other symptoms and signs involving the digestive system and abdomen	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**
R54	Senility	0	0	0	0	0	0	0	0	0	0	0	0	7	24	**7**	**24**
R57	Shock, not elsewhere classified	0	0	0	0	0	0	0	0	0	0	1	0	0	3	1	**3**
Total Group XVIII		**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**1**	**1**	**0**	**8**	**28**	**11**	**29**
Group XIX Injury, poisoning and certain other consequences of external causes																	
S28	Crushing injury of thorax and traumatic amputation of part of thorax	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**	**0**
T79	Certain early complications of trauma, not elsewhere classified	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**	**0**
Total Group XIX		**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**0**

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		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Group XX External causes of morbidity and mortality																	
X40	Accidental poisoning by and exposure to nonopoid analgesics, antipyretics and antirheumatics	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
X45	Accidental poisoning by and exposure to alcohol	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2	0
X47	Accidental poisoning by and exposure to other gases and vapours	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	1
X61	Intentional self-poisoning (suicide) by and exposure to antiepileptic, sedative-hypnotic, antiparkinson & psychotropic drugs, not elsewhere classified	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0
X70	Intentional self harm (suicide) by hanging, strangulation and suffocation	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
X72	Intentional self harm (suicide) by handgun discharge	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
X93	Assault (homicide) by handgun discharge	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Total Group XX		**0**	**0**	**0**	**0**	**1**	**0**	**2**	**1**	**1**	**1**	**2**	**1**	**0**	**0**	**6**	**3**
	Adjouned sine die	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Total Deaths		**4**	**1**	**0**	**0**	**1**	**0**	**12**	**6**	**29**	**16**	**45**	**26**	**169**	**208**	**260**	**257**

Alderney Vital Statistics - 2007

	Males	Females	Total 2007	5 year mean 1999-2003
Population	1,108	1,130	**2,238**	2,294
• **M : F**			**0.98**	0.97
Births - In Guernsey:	5	4	**9**	9.4
Births - In Alderney:	0	1	**1**	0.8
Total Births to Alderney residents:	5	5	**10**	10.2
Births outside marriage:	2	1	**3**	4.2 (41%)
Crude Birth Rate/000	-	-	**4.5**	4.5
Marriages registered in Alderney:			**15**	13
Deaths registered in Alderney:	17	13	**30**	22.8
Crude Death Rate/000			**13.4**	10.1
Natural Increase:*			**-20** **[-0.9%]**	-12.6 [-0.6%]

*Includes *'natural increase'*, but excludes net migration.

** *'Natural increase'* is the difference between the crude birth and the death rates, expressed as a percentage of the resident population.

Appendix Two

A.2 Staff providing public health services 2007

Director of Public Health/Medical Officer of Health
Dr David Jeffs FRCP FFPH FAFPHM FRSH

Personal Assistant
Mrs Yvonne Kaill

Part-time Medical Staff:

Deputy Medical Officer of Health
Dr Brian Parkin MB BS BSc FRCP MRCGP DRCOG

Sexual Health Clinic
Dr Nikki Brink MBChB MMed FRCPath

Guernsey Family Planning Clinic
Mrs Sue Le Page SRN

Infection Control

Mrs Elaine Burgess RSCN, ENB329/998, C&G 7307, MSc (Health Sciences)
Mrs Kay Bull RGN, ENB329/998

Environmental Health Department:

Director of Environmental Health and Pollution Regulation
Mr John Cook Chartered Environmental Health Practitioner

Deputy Chief Environmental Health Officer
Mr Tony Rowe MCIEH

Environmental Health Officers
Mrs Jane Cutting GradCIEH (from March 2007)
Mr Tobin Cook MSc Chartered Environmental Health Practitioner
Mr Stan Horton MCIEH (until October 2007)
Mr Stuart Wiltshire MCIEH

Waste Regulation Officer
Mr Simon Welch BSc(Hons) CEnv MCIWM CMIOSH AIEMA

Pest Control Operatives
Mr Paul Tostevin
Mr Michael Brache

Secretary
Ms Christine Vincent (until August 2007)
Mrs Diane Harding (from December 2007)

States Analyst Laboratory

States Analyst
Dr David Mortimer BA BSc (Hons) PhD CChem FRSC MCIWEM

Mr Laurence Knight BSc (Hons) CChem MRSC
Mr Michael Hughes BSc (Hons) MIBiol
Mrs Joanne Alder BSc (Hons)
Mrs C. Joan Le Tissier HNC
Dr Peter Atkinson BA MSc MPhil PhD
Mrs Carol Deveau

Health Promotion Unit:

Health Promotion Manager
Miss Yvonne Le Page Bed (Hons) PgDip (Health Promotion) FRSH

Health Promotion Officer (smoking and heart disease)
Mrs Gerry Le Roy RGN

Health Promotion Assistant (cancer)
Miss Helen MacLeod Dip Occ Therapy

Health Promotion Research Assistant (obesity)
Mrs Lucy Whitman MSc (Conservation Biology)
PGDip (Health Promotion)

Resources Officer
Mrs Stephanie Charlwood

Secretary
Mrs Bella Mahy

Clinical Governance:

Clinical Risk Manager
Mrs Jean Ellyatt RGN, SCM, CMS, Cert MHS (until June 2007)
Mrs Lynne Lewendon RGN (from June 2007)

PA to Clinical Risk Manager
Mrs Jo McGinn

Clinical Audit Nurses
Miss Eithne Downey RGN Dip HE BN MSc (Health Education)
Mrs Lynn Lewendon RGN (until June 2007)
Mr Brian O'Connell RN ILM Level 5 Dip in Management (from June 2007)

Quality Liaison
Mrs Jennifer Guezo RN, DipN, BSc (Hons) (seconded to the EHSCR Project)

Health Records and Healthcare Information

Healthcare Information Analysts
Mrs Helen Jones BSc (Hons)
Mrs Tamsin Lilley BSc
Mrs Jenny Elliott (from December 2007)

Health databases/Clinical Coding
Mrs Jenny Elliott (until December 2007)

Health Records Manager
Mr Michael Holland HND Computer Studies (BEC/TEC) (from August 2007)

Clinical Coders

Senior Clinical Coder
Mrs Margaret Cann ACC

Clinical Coder
Mrs Sue Sheppard

Notes

Notes